FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0032904

Facility Name: MANORCARE AT LIBERTYVILLE

Address: 1500 S. Milwaukee Ave. (Number) Libertyville (City) 60048 (Zip Code)

County: Lake

Telephone Number: (708) 816-3200 **Fax #** (708) 816-8981

IDPA ID Number: 520886946009

Date of Initial License for Current Owners: 02/02/88

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Dekany **Telephone Number:** (419) 252-5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/01 to 05/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Barry Lazarus

(Title) Vice President - Reimbursement

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number MANORCARE AT LIBERTYVILLE # 0032904 Report Period Beginning: 06/01/01 Ending: 05/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	140	Skilled (SNF)	150	54,140	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	10	Sheltered Care (SC)	0	610	5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,750	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,443	3,272	11,535	18,250	8
9	SNF/PED					9
10	ICF	21,078	7,868	1,081	30,027	10
11	ICF/DD					11
12	SC		378		378	12
13	DD 16 OR LESS					13
14	TOTALS	24,521	11,518	12,616	48,655	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.87%

D. How many bed-hold days during this year were paid by Public Aid?
3 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/23/88

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/23/88 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 60 and days of care provided 10,383

Medicare Intermediary CareFirst of Maryland, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12/31/02 Fiscal Year: 05/31/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MANORCARE AT LIBERTYVILLE # 0032904 Report Period Beginning: 06/01/01 Ending: 05/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	316,527	23,393	3,516	343,436	2,043	345,479		345,479			1
2	Food Purchase		222,467		222,467		222,467	(3,681)	218,786			2
3	Housekeeping	117,819	19,901	1,575	139,295		139,295		139,295			3
4	Laundry	36,273	19,722	1,749	57,744		57,744		57,744			4
5	Heat and Other Utilities			148,656	148,656	9,715	158,371		158,371			5
6	Maintenance	42,813	19,574	63,036	125,423		125,423		125,423			6
7	Other (specify):* Med Waste			2,772	2,772		2,772		2,772			7
8	**TOTAL General Services**	513,432	305,057	221,304	1,039,793	11,758	1,051,551	(3,681)	1,047,870			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	2,622,667	247,999	179,942	3,050,608	45,192	3,095,800		3,095,800			10
10a	Therapy	444,463	11,604	56,178	512,245		512,245		512,245			10a
11	Activities	101,988	5,314	2,082	109,384		109,384		109,384			11
12	Social Services	39,579			39,579		39,579		39,579			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,208,697	264,917	256,202	3,729,816	45,192	3,775,008		3,775,008			16
	C. General Administration											
17	Administrative	82,897		621,357	704,254	(355,756)	348,498		348,498			17
18	Directors Fees											18
19	Professional Services			7,124	7,124	(210)	6,914	(6,914)				19
20	Dues, Fees, Subscriptions & Promotions			67,391	67,391		67,391	(33,343)	34,048			20
21	Clerical & General Office Expenses	339,788	53,421	193,390	586,599		586,599	(217,216)	369,383			21
22	Employee Benefits & Payroll Taxes			788,217	788,217	15,033	803,250		803,250			22
23	Inservice Training & Education			2,324	2,324		2,324		2,324			23
24	Travel and Seminar			12,944	12,944		12,944		12,944			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			123,184	123,184		123,184		123,184			26
27	Other (specify):*											27
28	**TOTAL General Administration**	422,685	53,421	1,815,931	2,292,037	(340,933)	1,951,104	(257,473)	1,693,631			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,144,814	623,395	2,293,437	7,061,646	(283,983)	6,777,663	(261,154)	6,516,509			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MANORCARE AT LIBERTYVILLE #0032904 Report Period Beginning: 06/01/01 Ending: 05/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			319,675	319,675	52,114	371,789		371,789			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			16,705	16,705	231,869	248,574		248,574			32
33	Real Estate Taxes			139,251	139,251		139,251	3,010	142,261			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			65,471	65,471		65,471		65,471			35
36	Other (specify):*											36
37	**TOTAL Ownership**			541,102	541,102	283,983	825,085	3,010	828,095			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		261,289	7,624	268,913		268,913		268,913			39
40	Barber and Beauty Shops			26,964	26,964		26,964		26,964			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			81,120	81,120		81,120		81,120			42
43	Other (specify):*		75,470		75,470		75,470		75,470			43
44	**TOTAL Special Cost Centers**		336,759	115,708	452,467		452,467		452,467			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,144,814	960,154	2,950,247	8,055,215		8,055,215	(258,144)	7,797,071			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number MANORCARE AT LIBERTYVILLE # 0032904 Report Period Beginning: 06/01/01 Ending: 05/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,681)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(2,964)	21		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,645)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(10,237)	21		16
17	Non-Care Related Fees	(16,773)	21		17
18	Fines and Penalties	(10,140)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,914)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(174,457)	21		24
25	Fund Raising, Advertising and Promotional	(33,343)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	3,010	33		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (258,144)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (258,144)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

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Page 5A

MANORCARE AT LIBERTYVILLE

ID# 0032904

Report Period Beginning: 06/01/01

Ending: 05/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MANORCARE AT LIBERTYVILLE **#** 0032904 **Report Period Beginning:** 06/01/01 **Ending:** 05/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,681)	0	0	0	0	0	0	0	0	0	0	(3,681)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,681)	0	0	0	0	0	0	0	0	0	0	(3,681)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,914)	0	0	0	0	0	0	0	0	0	0	(6,914)	19
20	Fees, Subscriptions & Promotions	(33,343)	0	0	0	0	0	0	0	0	0	0	(33,343)	20
21	Clerical & General Office Expenses	(217,216)	0	0	0	0	0	0	0	0	0	0	(217,216)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(257,473)	0	0	0	0	0	0	0	0	0	0	(257,473)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(261,154)	0	0	0	0	0	0	0	0	0	0	(261,154)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MANORCARE AT LIBERTYVILLE # 0032904 **Report Period Beginning:** 06/01/01 **Ending:** 05/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	3,010	0	0	0	0	0	0	0	0	0	0	3,010	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	3,010	0	0	0	0	0	0	0	0	0	0	3,010	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(258,144)	0	0	0	0	0	0	0	0	0	0	(258,144)	45

Facility Name & ID Number MANORCARE AT LIBERTYVILLE # 0032904 Report Period Beginning: 06/01/01 Ending: 05/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Manor Care, Inc.	100	Health Care & Retirement Corporation of America (See H.O. Cost Report)	Toledo, OH.			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		See Page 8	Home Office Allocation	$ 621,357	HCR Manor Care, Inc.	100.00%	$ 621,357	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V		10a	Therapy Management	42,000	Heartland Management Services	100.00%	42,000		6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 663,357			$ 663,357	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number MANORCARE AT LIBERTYVILLE # 0032904 Report Period Beginning: 06/01/01 Ending: 05/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MANORCARE AT LIBERTYVILLE # 0032904 Report Period Beginning: 06/01/01 Ending: 05/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HCR Manor Care, Inc.
Street Address: 333 North Summit St.
City / State / Zip Code: Toledo, OH. 43604
Phone Number: (419)252-5500
Fax Number: (419)254-5494

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	$	$	7,279,077	$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	680,609	406,990	7,279,077	2,043	2
3	5	Utilities - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	154,435		7,279,077	555	3
4	5	Utilities - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	3,051,710		7,279,077	9,160	4
5	10	Nursing - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	10,993,908	7,606,940	7,279,077	39,483	5
6	10	Nursing - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	1,902,166	1,264,589	7,279,077	5,709	6
7	17	General & Admin - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	14,112,784	11,038,075	7,279,077	50,684	7
8	17	General & Admin - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	71,533,109	46,622,737	7,279,077	214,707	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	2,156,484		7,279,077	7,745	9
10	22	Employee Benefits - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	2,428,174		7,279,077	7,288	10
11	30	Depreciation - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	101,489		7,279,077	364	11
12	30	Depreciation - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	17,241,472		7,279,077	51,750	12
13										13
14	32	Interest				231,869			231,869	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 124,588,209	$ 66,939,331		$ 621,357	25

Facility Name & ID Number MANORCARE AT LIBERTYVILLE # 0032904 Report Period Beginning: 06/01/01 Ending: 05/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Conv. Sub. Debentures		X	Facility			$ 3,244,133	$ 3,244,133			$ 231,869	1
2	Bank of America						650,995	650,995			16,705	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 3,895,128	$ 3,895,128			$ 248,574	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,895,128	$ 3,895,128			$ 248,574	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number MANORCARE AT LIBERTYVILLE **#** 0032904 **Report Period Beginning:** 06/01/01 **Ending:** 05/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	136,241	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	139,251	2
3. Under or (over) accrual (line 2 minus line 1).	$	3,010	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	139,251	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	142,261	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	124,126	8
	1998	126,194	9
	1999	132,504	10
	2000	136,241	11
	2001	139,251	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MANORCARE AT LIBERTYVILLE COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0032904

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE (419) 252-5740 FAX #: (419) 254-5495

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-28-401-003	See Attached	$ 142,408.03	$ 142,408.03
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 142,408.03	$ 142,408.03

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number MANORCARE AT LIBERTYVILLE # 0032904 Report Period Beginning: 06/01/01 Ending: 05/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,902 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 3

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1988	$ 476,076	1
2	Facility		2000	9,118	2
3	TOTALS			$ 485,194	3

Facility Name & ID Number MANORCARE AT LIBERTYVILLE # 0032904 Report Period Beginning: 06/01/01 Ending: 05/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	150			1988	$ 4,592,131	$ 114,803		$ 114,803	$	$ 1,581,693	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	BUILDING IMPROVEMENTS (Current Year Depreciation)					137,871		137,871		963,908	9
10				1988	68,073						10
11				1989	52,434						11
12				1990	30,247						12
13				1991	67,316						13
14				1992	175,480						14
15				1993	55,746						15
16				1994	135,262						16
17				1995	66,532						17
18	FLOOR VINYL/TILE & INSTALLATION			1996	31,353						18
19	CAPITALIZED LABOR-NURSES STATION RENOV			1996	7,272						19
20	WALLVINYL/SIGNS			1996	5,576						20
21	CARPET			1996	4,210						21
22	INNER CAMERA MONITOR			1996	4,177						22
23	SIDING			1996	2,205						23
24	REPAIR LOOSE BRICKS			1996	2,183						24
25	NURSES STATION RENOVATION			1996	11,271						25
26	DOOR RELEASE			1996	2,071						26
27	REMODELING			1996	1,129						27
28	WATER HEATER			1996	5,313						28
29	CARPET/INSTALLATION			1996	2,991						29
30	FLOORING/TILE			1996	23,312						30
31	DOOR FRAME/GUARDS			1996	4,941						31
32	KITCHEN CELING TILE			1996	3,638						32
33	WALLCOVERINGS			1996	4,964						33
34	ELECTRICAL/LIGHTING			1996	3,055						34
35	CABINETRY			1996	5,880						35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number MANORCARE AT LIBERTYVILLE # 0032904 Report Period Beginning: 06/01/01 Ending: 05/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	REBUILD NURSES STATION	1996	$ 8,500	$		$	$	$	37
38	INSTALL SWING DOORS	1996	8,826						38
39	INSTALL BALLUSTER POSTS	1996	2,500						39
40	FLOOR COVING	1996	7,791						40
41	BRICK PIER/CONCRETE SIDEWALK	1996	3,880						41
42	INSTALL BOULDER EDGE	1996	4,830						42
43	NURSES STATION RENOVATIONS	1996	1,506						43
44	WALLVINYL	1997	18,304						44
45	CARPETING	1997	1,624						45
46	DECORATING	1997	45,045						46
47	BRICK PIER	1997	1,500						47
48	EXTERIOR ENTRY DOORS	1997	3,317						48
49	PAINTING	1997	7,449						49
50	INSTALL CONDENSING COILS	1997	2,583						50
51	LANDSCAPE	1997	59,118						51
52	CURBING/ASPHALT	1997	30,000						52
53	ROOFING	1997	1,536						53
54	CORPORATE OVERHEAD-PARKING LOT	1997	10,516						54
55	RETIREMENTS	1992	(10,437)						55
56	PARKING LOT WORK	1997	25,000						56
57	FACILITY PLAN ALLOC	1997	5,964						57
58	ELEVATOR REPAIRS	1997	5,018						58
59	SECURITY SYSTEM	1997	16,954						59
60	NEW EXHAUSTERS	1997	6,310						60
61	BUILD & INSTALL CABINETS	1997	6,512						61
62	CARPET	1997	5,148						62
63	LANDSCAPE	1997	25,279						63
64	CURB/ASPHALT	1997	45,210						64
65	INSTALL CEDAR FENCE	1997	2,750						65
66	DRUM SLUDGE REMOVAL	1997	2,563						66
67	INSTALL OIL TANK	1997	11,779						67
68	FLOORING/CEILING	1998	1,115						68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,736,752	$ 252,674		$ 252,674	$	$ 2,545,601	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MANORCARE AT LIBERTYVILLE # 0032904 Report Period Beginning: 06/01/01 Ending: 05/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,736,752	$ 252,674		$ 252,674	$	$ 2,545,601	1
2	CARPETING	1998	2,574						2
3	ARCHITECT/PROFESSIONAL FEES-ADMIN OFFICE	1998	3,685						3
4	PAINTING/WALLPAPER	1998	10,125						4
5	RENOVATE ADMIN OFFICE	1998	2,533						5
6	ENERGY AUDITS	1998	1,875						6
7	GENERAL CONTRACTOR FEES-ADMIN OFFICE	1998	4,165						7
8	CORPORATE OVERHEAD-ADMIN OFFICE	1998	1,651						8
9	INSTALL FENCE/GAZEBO	1998	2,153						9
10	PAINTING/WALLCOVERING	1998	5,821						10
11	PLUMBING	1998	5,250						11
12	ELECTRICAL	1998	8,883						12
13	DEVELOPERS-ADMIN OFFICE	1998	5,555						13
14	SIGN	1998	11,862						14
15	ROOFING	1998	5,520						15
16	MASONARY	1998	4,766						16
17	CARPENTRY	1998	3,137						17
18	PAINTING/WALLCOVERING	1999	6,873						18
19	ELECTRICAL	1999	6,590						19
20	FLOORING/CEILING	1999	8,230						20
21	CARPENTRY	1999	12,373						21
22	MILLWORK	1999	540						22
23	FINISH STUDS	1999	20,000						23
24	PAVING	1999	35,325						24
25	CARPET FOR BUILDING	1999	11,611						25
26	WINDOW TREATMENTS	1999	10,291						26
27	KNOBLOCKS, CYPHER	1999	1,448						27
28	CARPET, CREDIT	1999	(13,990)						28
29	SALES TAX, CARPET	1999	71						29
30	CARPET	1999	148						30
31	DOOR FRAME FOR BOILER ROOM	1999	2,550						31
32	ELECTRICAL CIRCUITS, HEATER	1999	5,937						32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,924,304	$ 252,674		$ 252,674	$	$ 2,545,601	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MANORCARE AT LIBERTYVILLE # 0032904 Report Period Beginning: 06/01/01 Ending: 05/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,924,304	$ 252,674		$ 252,674	$	$ 2,545,601	1
2	DOOR, HARDWARE, & STAIN	2000	1,025						2
3	PTAC UNITS	1999	2,920						3
4	ADDTL COST GARAGE	2000	1,671						4
5	SECURE CARE SYS 2ND FL STAIRWELL	2000	3,147						5
6	DOOR - SOUTH CORRIDOR EXIT	2000	2,440						6
7	PANIC DEVICE - EXTERIOR DOOR	2000	760						7
8	BOILER	2001	4,525						8
9	FIRE WALL IN ATTIC	2001	7,422						9
10	A/C UNIT	2001	597						10
11	2 A/C UNITS	2000	1,156						11
12	4 A/C UNITS	2001	2,680						12
13	WORKCOUNTER & CABINETS	2001	2,219						13
14	GARAGE	2000	21,256						14
15	LANDSCAPING	2000	2,675						15
16	LANDSCAPING - ARBORIVITAE	2000	3,784						16
17	GARAGE	2000	19,209						17
18	GARAGE	2000	5,556						18
19	GATES	2001	4,760						19
20	ELECTRICAL CIRCUITS	2001	1,279						20
21	ARCADIA CORRIDORS& LOUNGE RENOVATIONS	2001	132,623						21
22	ARCADIA CORRIDORS& LOUNGE RENOVATIONS	2001	5,666						22
23	ARCADIA CORRIDORS& LOUNGE RENOVATIONS	2001	124,865						23
24	ARCADIA CORRIDORS& LOUNGE RENOVATIONS	2001	20,483						24
25	ARCADIA CORRIDORS& LOUNGE RENOVATIONS	2001	181,656						25
26	CARPENTRY, DOORS, ELECT.	2001	52,344						26
27	VWC, CORNER GUARDS	2001	10,041						27
28	C/R 5/31/99 AUDIT ADJ. - CAPITAL LABOR	1996	(7,272)	(727)		(727)		(4,545)	28
29	C/R 5/31/99 AUDIT ADJ. - FAC PLAN ALLOC	1997	(10,516)	(1,052)		(1,052)		(5,433)	29
30	C/R 5/31/99 AUDIT ADJ. - FAC PLAN ALLOC	1997	(3,206)	(321)		(321)		(1,550)	30
31	C/R 5/31/99 AUDIT ADJ. - FAC PLAN ALLOC	1997	(2,759)	(276)		(276)		(1,218)	31
32	C/R 5/31/99 AUDIT ADJ.-MONTHLY CAP BUDGET	1998	(1,651)	(165)		(165)		(660)	32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,515,661	$ 250,134		$ 250,134	$	$ 2,532,195	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MANORCARE AT LIBERTYVILLE # 0032904 Report Period Beginning: 06/01/01 Ending: 05/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 647,583	$ 69,541	$ 69,541	$		$ 467,711	71
72	Current Year Purchases	181,605						72
73	Fully Depreciated Assets							73
74	Home Office Allocation			52,114	52,114			74
75	TOTALS	$ 829,188	$ 69,541	$ 121,655	$ 52,114		$ 467,711	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,830,043	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 319,675	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 371,789	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 52,114	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,999,906	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 65,471 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elect. Beds, Etc.
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number MANORCARE AT LIBERTYVILLE # 0032904 Report Period Beginning: 06/01/01 Ending: 05/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	4690	hrs	$ 110,580	937	$ 23,419	$ 732	5,627	$ 134,731	1
2	Licensed Speech and Language Development Therapist	10a	3004	hrs	70,835	485	12,115	336	3,489	83,286	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	11156	hrs	263,048	826	20,644	10,536	11,982	294,228	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39,2		# of prescrpts				261,289		261,289	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): P/S Podi.,X-Ray,Lab	39,3					7,624			7,624	13
14	TOTAL				$ 444,463	2,247	$ 63,802	$ 272,893	21,097	$ 781,158	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number MANORCARE AT LIBERTYVILLE # 0032904 **Report Period Beginning:** 06/01/01 **Ending:** 05/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 05/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 27,451	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (203,812))	1,363,394		3
4	Supply Inventory (priced at)	14,048		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	7,651		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,412,544	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	485,194		13
14	Buildings, at Historical Cost	6,515,661		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	829,188		16
17	Accumulated Depreciation (book methods)	(2,999,906)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,830,137	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,242,681	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 31,455	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	381,238		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	69,625		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	50,741		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 533,059	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	650,995		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 650,995	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,184,054	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,058,627	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,242,681	$	48

***(See instructions.)**

Facility Name & ID Number MANORCARE AT LIBERTYVILLE # 0032904 Report Period Beginning: 06/01/01 Ending: 05/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,283,672	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,283,672	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	722,305	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 722,305	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(947,350)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (947,350)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 5,058,627	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number MANORCARE AT LIBERTYVILLE # 0032904 Report Period Beginning: 06/01/01 Ending: 05/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,575,542	1
2	Discounts and Allowances for all Levels	(1,705,259)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,870,283	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,472,124	6
7	Oxygen	(520)	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,471,604	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	2,596	12
13	Barber and Beauty Care	31,464	13
14	Non-Patient Meals	1,085	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	265,843	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	97,232	19
20	Radiology and X-Ray		20
21	Other Medical Services	312	21
22	Laundry	23,292	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 421,824	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	16,773	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 16,773	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	(2,964)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (2,964)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,777,520	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,039,793	31
32	Health Care	3,729,816	32
33	General Administration	2,292,037	33
	B. Capital Expense		
34	Ownership	541,102	34
	C. Ancillary Expense		
35	Special Cost Centers	452,467	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,055,215	40
41	**Income before Income Taxes (line 30 minus line 40)****	722,305	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 722,305	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number MANORCARE AT LIBERTYVILLE # 0032904 Report Period Beginning: 06/01/01 Ending: 05/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,240	2,432	$ 75,864	$ 31.19	1
2	Assistant Director of Nursing	1,701	1,846	47,985	25.99	2
3	Registered Nurses	38,411	41,705	970,511	23.27	3
4	Licensed Practical Nurses	15,752	17,103	308,884	18.06	4
5	Nurse Aides & Orderlies	105,953	115,041	1,179,942	10.26	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	16,576	17,988	424,148	23.58	7
8	Rehab/Therapy Aides	1,927	2,092	20,315	9.71	8
9	Activity Director	8,271	8,972	101,988	11.37	9
10	Activity Assistants					10
11	Social Service Workers	1,847	2,004	39,579	19.75	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	28,274	30,743	316,527	10.30	15
16	Dishwashers					16
17	Maintenance Workers	3,301	3,633	42,813	11.78	17
18	Housekeepers	13,237	14,365	117,819	8.20	18
19	Laundry	4,484	4,863	36,273	7.46	19
20	Administrator	2,387	2,080	82,897	39.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,439	20,267	339,788	16.77	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,279	3,564	39,481	11.08	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	266,079	288,698	$ 4,144,814 *	$ 14.36	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	18,000	5,9,3	36
37	Medical Records Consultant	Monthly	4,680	5,10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,889	5,10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 30,569		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,762	$ 136,379	5,10,3	50
51	Licensed Practical Nurses	570	10,301	5,10,3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	2,332	$ 146,680		53

Facility Name & ID Number MANORCARE AT LIBERTYVILLE # 0032904 Report Period Beginning: 06/01/01 Ending: 05/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michele Grabarski	Administrator	0	$ 82,897
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 82,897

B. Administrative - Other

Description	Amount
H.O. Allocation	$ 621,357
TOTAL (agree to Schedule V, line 17, col. 3)	$ 621,357
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Van Ostrand & Elvidge Kelley	Legal Fees	$ 6,914
Weissman Group	H/R Consultant	210
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 7,124

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 150,222
Unemployment Compensation Insurance	39,681
FICA Taxes	300,734
Employee Health Insurance	191,090
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Appreciation	9,968
Payroll Overhead Allocated	0
Employee Uniforms	2,269
401K / SMSP Match	14,860
Other Employee Benefits	76,561
Tuition Program	2,832
Home Office Allocation	15,033
TOTAL (agree to Schedule V, line 22, col.8)	$ 803,250

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 210
Advertising: Employee Recruitment	26,299
Health Care Worker Background Check	1,908
(Indicate # of checks performed 76)	
Dues & Subscriptions	967
Association Dues	6,791
Advertising	31,216
Less: Non-Allowable Assoc Due	(2,127)
Less: Public Relations Expense	( )
Non-allowable advertising	(31,216)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 34,048

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	12,944
Includes travel expense to the Home	
Office in Toledo, OH for regional	
meeting	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,944

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MANORCARE AT LIBERTYVILLE # 0032904 Report Period Beginning: 06/01/01 Ending: 05/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
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16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number MANORCARE AT LIBERTYVILLE **#** 0032904 **Report Period Beginning:** 06/01/01 **Ending:** 05/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $6,791**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **67,288** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **81,120**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **(1,085)**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.